MDR: M4-02-4337-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

- 1. a. Whether there should be reimbursement for dates of service 07/20/01 and 07/24/01.
  - b. The request was received on 07/03/02.

## II. EXHIBITS

- 1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. HCFAs-1500
  - c. EOBs
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
- 2. Respondent, Exhibit II: No Response
- 3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the requestor's 14 day additional information on 08/26/02. The insurance carrier did not submit a response to the additional information. The carrier was notified by mail that the request for medical dispute resolution was filed on 07/25/02. The case file does not contain a three day response from the carrier. The "No Information Found In Case File" sheet is reflected in Exhibit II of the Commission's Case File.
- 4. Notice of "A letter Requesting Additional Information" is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

- 1. Requestor: No position statement
- 2. Respondent: No Response

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 07/20/01 and 07/24/01.

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- 2. Per the provider's TWCC-60, the amount billed is \$1,451.00; the amount paid is \$0.00; the amount in dispute is \$1,315.
- 3. The carrier's denial exception codes for dates of service include, "\*00850 TAL TO A PROCEDURE PERFORMED ON THE SAME DATE OF SERVICE; \*00850 DELINES."
- 4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or	BILLED	PAID	EOB Denial	MAR\$	REFERENCE	RATIONALE:
	Revenue CODE			Code			
07/20/01	99242	\$90.00	\$0.00	*00850	\$90.00	Rule 133.304 (c); CPT descriptor	Rule 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the Commission's instructions or provide the provider with sufficient explanation to allow to allow the provider to understand the reason for the denial. Reimbursement in the amount of \$90.00 is recommended.
07/24/01 for all CPT codes	62289-WP 72265-26 76003-26 A4645	\$263.00 \$60.00 \$60.00 \$100.00	\$0.00 for all CPT this	*00850 all CPT codes this DOS	\$263.00 \$60.00 \$52.00 DOP	Rule 133.304 (c); CPT descriptor	Rule 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission,
	72100-WP 71010-WP 93005-WP 94760-WP 99499-RR 00630-46	\$56.00 \$41.00 \$26.00 \$65.00 \$80.00 \$350.00	DOS		\$56.00 \$41.00 \$26.00 \$52.00 DOP \$245.00		the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's
	00030 10	ψ330.00			(\$35.00 per RVU)	MFG AGR (I) (B) (1-4), (II) (C); CPT	action(s)" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the
	J3010 J2000 A4550	\$25.00 \$10.00 \$75.00			DOP DOP DOP	descriptor	Commission's instructions or provide the provider with sufficient explanation to allow the provider to understand the reason for the denial.
	J3360 A4215 J7040	\$25.00 \$5.00 \$75.00			DOP DOP DOP		Reimbursement in the amount of \$1,210.00 is recommended.
	J2765 99070 99070	\$25.00 \$10.00 \$10.00			DOP DOP DOP		
Totals		\$1,451.00	\$0.00		I		The Requestor is entitled to reimbursement in the amount of \$1,300.00.

The above Findings and Decision are hereby issued this 9th day of December 2002.

Donna M. Myers Medical Dispute Resolution Officer Medical Review Division

DMM/dmm